STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey dates: January 22, 23, 24, 25, and 28, 2013 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Survey team: Diana Sidell RN, TC Gloria Reisert, MSW Jill Ross RN (January 22, 23, 24, and 25, 2013) Census bed type: SNF/NF: 90 Total: 90 Census payor type: Medicare: 9 Medicaid: 65 Other: 16 Total: 90 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Please find the enclosed plan of correction for survey ending January 28, 2013. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on record review, interview and observation the facility failed to do a complete and accurate assessment of an incontinent resident. This affected 1 of 3	F0272	1. Resident#20 had a 3-day voiding diary and bladder assessment completed. IDT conducted a bladder continence review. 2. All residents have the potential to be affected. Bladder	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents reviewed for assessments. (Resident #20) Findings include: Record review for Resident #20 was done on 1/23/13 at 2:00 p.m. Diagnoses included, but were not limited to: CVA (stroke) with right sided paralysis, high blood pressure, depression, expressive aphasia (cannot speak) and congestive heart failure. There was no assessment done to show how often the resident required to be toileted to be kept dry. An interview with Resident #20's daughter was done on 1/23/13 at 11:45 a.m. She indicated she put her mother's call light on at 11:30 a.m., so they could take her mother to the bathroom. At 11:55 a.m., staff came to take resident to the bathroom. They also took clean clothes as the resident had been incontinent. The daughter indicated her mother has a weak bladder and went to the bathroom every hour when she was home. She indicated they have told staff since the resident came into the facility but they will not toilet her as she needs to be.		assessments were completed on all residents. Toileting programs and care plans were updated accordingly. 3. Continence assessment to be conducted quarterly and upon a significant change on all residents by the DNS or designee. IDT will conduct bladder continent review to ensure a toileting program is in place if appropriate and will develop a plan of care if appropriate. All nursing staff in-serviced by SDC on the following by 2-1-13: Bladder Program Policy and Procedure (See Attachment A), Bladder Continence (See Attachment B), Restorative Nursing Programs Policy and Procedure (See Attachment C), FIT Toileting Program (See Attachment D), Scheduled Toileting Evaluation (See Attachment E), Instructions for Completion of ADL Record Policy and Procedure (See Attachment F), Documentation Guidelines for Nursing (See Attachment G), and Care Plan Review and Maintenance Process Policy and Procedure (See Attachment H). 4. DNS or designee will complete a Bladder Program Audit Tool (See Attachment H) 5 days a week times 4 weeks for all new admissions/readmissions and residents with an Assessment Reference Date, then up to 10 residents weekly times 4 weeks, then every other week times 4 weeks, then monthly times 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview with the MDS Coordinator was done on 1/25/13 at 2:50 p.m. She indicated the CNA's are not required to chart what happened each time they check a resident. "They only have to mark if the resident was continent or incontinent on their shift." A policy titled, "Bladder Program" was received from the Director of Nursing on 1/28/13 at 10:37 a.m. This policy indicated, "...3. The resident should be checked and offered toileting every hour during waking hours..." 3.1-31(a)		months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, interview and observation the facility failed to implement a care plan that would meet the needs of the resident. This affected 1 of 23 residents reviewed for care plans. (Resident #20) Findings include: Record review for Resident #20 was done on 1/23/13 at 2:00 p.m. Diagnoses included, but were not limited to: CVA (stroke) with right sided paralysis, high blood pressure, depression, expressive aphasia (cannot speak) and congestive heart failure.	F0279	1. Resident #20 had a 3-day voiding diary and bladder assessment completed. IDT conducted a bladder continence review. Care plan developed to address resident incontinence. CNA assignment sheet updated based on care plan. 2. All residents have the potential to be affected. Bladder assessments were completed on all residents. Toileting programs and care plans were updated accordingly. 3. IDT will conduct bladder continent review to ensure a care plan is developed quarterly and upon a significant change for all residents as appropriate. MDS	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan, with an initial date of 7/8/10, indicated to assist resident with toileting and peri care after each incontinent episode. "Toilet Q 2 (every 2 hours) and PRN (as needed) while awake." An interview with Resident #20's daughter was done on 1/23/13 at 11:45 a.m. She indicated she put her mother's call light on at 11:30 a.m., so they could take her mother to the bathroom. At 11:55 a.m., staff came to take resident to the bathroom. They also took clean clothes as the resident had been incontinent. The daughter indicated her mother has a weak bladder and went to the bathroom every hour when she was home. She indicated they have told staff since the resident came into the facility but they will not toilet her as she needs to be. An interview with the MDS Coordinator was done on 1/25/13 at 2:50 p.m. She indicated the CNA's are not required to chart what happened each time they check a resident. "They only have to mark if the resident was continent or incontinent on their shift." A policy titled, "Bladder Program" was received from the Director of Nursing on 1/28/13 at 10:37 a.m. This policy indicated, "...3. The resident should be checked and offered toileting every hour during waking hours..."		coordinator will ensure care plans are developed within 3 days of IDT review. All nursing staff in-serviced by SDC on the following by 2-1-13: Bladder Program Policy and Procedure (See Attachment A), Bladder Continence (See Attachment B), Restorative Nursing Programs Policy and Procedure (See Attachment C), FIT Toileting Program (See Attachment D), Scheduled Toileting Evaluation (See Attachment E), Instructions for Completion of ADL Record Policy and Procedure (See Attachment F), Documentation Guidelines for Nursing (See Attachment G), and Care Plan Review and Maintenance Process Policy and Procedure (See Attachment H). 4. DNS or designee will complete a Care Plan Review Audit Tool (See Attachment J) 5 days a week times 4 weeks for all new admissions/readmissions and residents with an Assessment Reference Date, then up to 10 residents weekly times 4 weeks, then every other week times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-35(a) 3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. Based on record review, interview and observation the facility failed to ensure the resident was toileted according to her needs for a resident who was totally dependent on staff. This affected 1 of 3 residents reviewed for ADL decline. (Resident #20) Findings include: Record review for Resident #20 was done on 1/23/13 at 2:00 p.m. Diagnoses included, but were not limited to: CVA (stroke) with right sided paralysis, high blood pressure, depression, expressive aphasia (cannot speak) and congestive heart failure. There was no assessment done to show how often the resident required to be toileted to be kept dry.	F0310	1. Resident #20 had a 3-day voiding diary and bladder assessment completed. IDT conducted a bladder continence review. Toileting is accommodating to her needs. 2. All residents have the potential to be affected. Bladder assessments were completed on all residents. Toileting programs and care plans were updated accordingly. CNA assignment sheets updated. Residents toileted per bladder assessments and care plans. 3. DNS or designee will conduct rounds every day on all shifts to ensure residents are toileted per the CNA assignment sheets. All nursing staff in-serviced by SDC on the following by 2-1-13: Bladder Program Policy and Procedure (See Attachment A), Bladder Continence (See Attachment B), Restorative Nursing Programs Policy and Procedure (See Attachment C), FIT Toileting Program (See Attachment D), Scheduled Toileting Evaluation	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a walk down the hall on 1/22/13 at 2:45 p.m., Resident #20's clothing was observed to be wet, and there was a puddle on the floor under her wheelchair. An interview with Resident #20's daughter was done on 1/23/13 at 11:45 a.m. She indicated she put her mother's call light on at 11:30 a.m., so they could take her mother to the bathroom. At 11:55 a.m., staff came to take resident to the bathroom. They also took clean clothes as the resident had been incontinent. The daughter indicated her mother has a weak bladder and went to the bathroom every hour when she was home. She indicated they have told staff since the resident came into the facility but they will not toilet her as she needs to be. On 1/25/13 at 11:41 a.m., incontinence care was provided for Resident #20. Her clothes were wet. CNA #1 indicated they do not have to document if the resident was dry or did not urinate. When the documentation was pulled to show her urine output there was nothing recorded even though the resident was wet at the time of the incontinence care.		(See Attachment E), Instructions for Completion of ADL Record Policy and Procedure (See Attachment F), Documentation Guidelines for Nursing (See Attachment G), and Care Plan Review and Maintenance Process Policy and Procedure (See Attachment H). 4. DNS or designee will complete a Bladder Program Audit Tool (See Attachment I) 5 days a week times 4 weeks for all new admissions/readmissions and residents with an Assessment Reference Date, then up to 10 residents weekly times 4 weeks, then every other week times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview with Resident #20's spouse was done on 1/25/13 at 12:00 p.m. He indicated he put the resident's light on yesterday (1/24/13) at 11:35 a.m. A CNA came into the room and shut the light off and said she would be right back. At 12:00 p.m., he wheeled her up to the shower room so they could toilet her. He had to ask staff to take care of her. All her clothing was now wet. An interview with CNA #2 was done on 1/25/13 at 10:00 a.m. She indicated this resident was more incontinent than continent. The MDS dated 1/7/13 indicated resident was not on a toileting program and "is always incontinent (no episodes of continent voiding)". An interview with the MDS Coordinator was done on 1/25/13 at 2:50 p.m. She indicated they are not considered on a toileting program unless it is done on paper. They may toilet a resident every 2 hours but if it is not written on paper it is not considered a toileting program. She also indicated the CNA's are not required to chart what happened each time they check a resident. "They only have to mark if the resident was continent or incontinent on their shift."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy titled, "Bladder Program" was received from the Director of Nursing on 1/28/13 at 10:37 a.m. This policy indicated, "...3. The resident should be checked and offered toileting every hour during waking hours..." 3.1-38(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review, interview and observation the facility failed to ensure a resident totally dependent on staff was toileted as often as needed to keep the resident dry. This affected 1 of 3 residents reviewed for ADL (activities of daily living) decline. (Resident #20) Findings include: Record review for Resident #20 was done on 1/23/13 at 2:00 p.m. Diagnoses included, but were not limited to: CVA (stroke) with right sided paralysis, high blood pressure, depression, expressive aphasia (cannot speak) and congestive heart failure. There was no assessment done to show how often the resident required to be toileted to be kept dry. During a walk down the hall on 1/22/13 at 2:45 p.m., Resident #20's clothing was observed to be wet and	F0312	1. Resident #20 had a 3-day voiding diary and bladder assessment completed. IDT conducted a bladder continence review. Toileting is accommodating to her needs. 2. All residents have the potential to be affected. Bladder assessments were completed on all residents. Toileting programs and care plans were updated accordingly. CNA assignment sheets updated. Residents toileted per bladder assessments and care plans. 3. DNS or designee will conduct rounds every day on all shifts to ensure residents are toileted per the CNA assignment sheets. All nursing staff in-serviced by SDC on the following by 2-1-13: Bladder Program Policy and Procedure (See Attachment A), Bladder Continence (See Attachment B), Restorative Nursing Programs Policy and Procedure (See Attachment C), FIT Toileting Program (See Attachment D), Scheduled Toileting Evaluation (See Attachment E), Instructions for Completion of ADL Record Policy and Procedure (See Attachment F), Documentation Guidelines for Nursing (See	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	there was a puddle on the floor under her wheelchair. An interview with Resident #20's daughter was done on 1/23/13 at 11:45 a.m. She indicated she put her mother's call light on at 11:30 a.m., so they could take her mother to the bathroom. At 11:55 a.m., staff came to take resident to the bathroom. They also took clean clothes as the resident had been incontinent. The daughter indicated her mother has a weak bladder and went to the bathroom every hour when she was home. She indicated they have told staff since the resident came into the facility but they will not toilet her as she needs to be. On 1/25/13 at 11:41 a.m., incontinence care was provided for Resident #20. Her clothes were wet. CNA #1 indicated they do not have to document if the resident was dry or did not urinate. When the documentation was pulled to show her urine output there was nothing recorded even though the resident was wet at the time of the incontinence care. An interview with Resident #20's spouse was done on 1/25/13 at 12:00 p.m. He indicated he put the		Attachment G), and Care Plan Review and Maintenance Process Policy and Procedure (See Attachment H). 4. DNS or designee will complete a Bladder Program Audit Tool (See Attachment I) 5 days a week times 4 weeks for all new admissions/readmissions and residents with an Assessment Reference Date, then up to 10 residents weekly times 4 weeks, then every other week times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

resident's light on yesterday (1/24/13) at 11:35 a.m. A CNA came into the room and shut the light off and said she would be right back. At 12:00 p.m., he wheeled her up to the shower room so they could toilet her. He had to ask staff to take care of her. All her clothing was now wet.

An interview with CNA #2 was done on 1/25/13 at 10:00 a.m. She indicated this resident was more incontinent that continent.

The MDS dated 1/7/13 indicated resident was not on a toileting program and "is always incontinent (no episodes of continent voiding)".

An interview with the MDS Coordinator was done on 1/25/13 at 2:50 p.m. She indicated they are not considered on a toileting program unless it is done on paper. They may toilet a resident every 2 hours but if it is not written on paper it is not considered a toileting program. She also indicated the CNA's are not required to chart what happened each time they check a resident. "They only have to mark if the resident was continent or incontinent on their shift."

A policy titled, "Bladder Program" was received from the Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 1/28/13 at 10:37 a.m. This policy indicated, "...3. The resident should be checked and offered toileting every hour during waking hours..." 3.1-38(a)(3)(A)(B)(C)(D)(E)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were labeled in	F0431	1. Resident #22 and Resident #55 medications were labeled appropriately. 2. All residents have the potential to be affected. Nursing Management	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance with accepted standards of practice, for 2 of 3 medications carts and 2 of 90 residents. (Resident #22 and #55) Findings include: During a medication cart observation, on 1/25/13, at 9:18 a.m., with LPN #3, the medication cart for the 300 hall was observed to have the following: - 1 bottle of Equate allergy and sinus tablets that had Resident #22's name written on the bottle with a marker, and contained no label with the required information. - 2 boxes that contained 1 bottle each of 'Omeprazole' (reduces stomach acid) with Resident #55's name written on the boxes and contained no label with the required information. - 1 bottle of 'Tylenol' 325 milligrams, with Resident #55's name written with a marker and had no label with the required information. - 1 bottle vitamin C, 500 milligrams, with Resident # 55's name written with a marker, and had no label with the required information. - 1 bottle loratadine, 10 milligrams (for allergies), that had Resident #55's name written on with a marker, and contained no label with the required information.		completed a 100% audit on all medications in the medication cart and found no further issues. 3. IDT will explain to all newly admitted residents and their families the protocol for having labels on Over the Counter Medications that are brought into thefacility from outside pharmacy sources during the Road to Recovery/Cottage meetings and also discussed during care plan meetings. All nursing staff in-serviced by SDC by 2-1-13 on Pharmakon Labeling of Medication Policy and Procedure (See Attachment K). 4. DNS or designee will complete a Medication Rooms and Carts Audit (See Attachment L) on all medication carts 3 times a week times 2 weeks, then 2 times a week times 2 weeks, then once a week times a month, then once a month times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 1 bottle 'col-rite' stool softener, 100 milligrams, with resident #55's name written with a marker, and no label with the required information. - 1 bottle folic acid with no name or label. During a medication cart observation, on 1/25/13, at 2:51 p.m., with LPN #4, the medication cart on the 400 hall was observed to have the following: - 3 bottles of 81 milligrams aspirin with no label and no resident name - 1 bottle of vitamin D3 with no label and no resident name - 1 bottle of 'One A Day' vitamins with no label and no resident name - 1 bottle of "Preservision' with no label and no resident's name - 1 box 'Sudafed PE' pressure and pain with no label and no resident's name During an interview on 1/25/13 at 2:55 p.m., LPN #4 indicated the family brought in the medications. A policy and procedure for "Labeling of Medication" was provided by the Director of Health Services on 1/28/13 at 12:37 a.m. The policy included, but was not limited to, "Purpose: To ensure all prescriptions are labeled in accordance with state and federal regulations...Procedure:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6.01 All Medications with a prescribers order: Labeling for all medications must be: Typed or printed and clearly indicate: Resident/patient full name, Prescription number, Name and strength of the drug, Route and time(s) the medication is to be given (if indicated on the prescription order), Quantity of drug/medication dispensed, Date dispensed, Expiration date of all time dated drugs, Prescriber's name, The name, address, and telephone number of the dispensing pharmacy, Any other pertinent information as may be needed or required...All non-prescription (OTC) medications or vitamin supplements supplied by [Pharmacy] will bear a prescription label which will contain all information as specified in 6.01 in this manual. All non-prescription (OTC) medications or vitamin supplements supplied by the resident or residents family must bear a prescription label which will contain all information as specified in section 6.01 in this manual. All OTC medications must be prescribed by a physician and written on a telephone order or admission order or other legal prescription...." 3.1-25(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-25(k)(1)(2)(3)(4)(5)(6)(7) 3.1-25(o)			